Statement of Deficiencies

8817-A: Administrative File **Not Met**

Findings/Corrections

8817 A. 6. The Provider's administrative file failed to include all leases, contracts, and purchase-of-service agreements to which the Provider was a party, which includes all appropriate credentials. DIETICIAN AGREEMENT IS NOT ON FILE.
8817 A. 7. The Provider's administrative file failed to include a current comprehensive general business insurance policy or policies in an amount adequate to cover all foreseeable occurrences, personal or professional negligence, malpractice or misconduct by facility owners or employees, injuries received by any resident while being transported by facility staff or third-party contractors, and injuries sustained by any resident while in the facility without limitations or exclusions of any kind. INSURANCE DOES NOT INCLUDE COVERAGE FOR INJURIES SUSTAINED BY ANY RESIDENT WHILE IN THE FACILITY OR BEING TRANSPORTED BY THE FACILITY WITHOUT LIMITATIONS OR EXCLUSIONS OF ANY KIND.

8817-F: Orientation **Not Met**

Findings/Corrections

8817 F. 1. (a.-.e.) The Provider's orientation program failed to include training in the following topics for staff [DOH 8/1/04]: a) the policies and procedures of the facility; b) emergency and evacuation procedures; c) resident's rights; d) procedures for and legal requirements concerning the reporting of abuse and critical incidents; and e) instruction in the specific responsibilities of the employee's job.
*ONE NEW EMPLOYEE HIRED DURING THE LAST 12 MONTHS. THERE WAS NO DOCUMENTATION THAT SHE RECEIVED THE REQUIRED TRAINING.
8817 F. 2. (a.-c.) Orientation for direct care staff, [DOH 8/1/04], failed to include an additional five days of supervised training in the following: a) resident care services (ADLs and IADLS) provided by the facility; b) infection control to include blood borne pathogens; and c) any specialized training to meet residents' needs. ORIENTATION WAS NOT DOCUMENTED FOR ONE OF ONE NEWLY HIRED STAFF.
8817 F. 3. A new employee, [DOH 8/1/04], was given sole responsibility for the implementation of a client's program plan before the five day supervised training was completed.
8817 F. 6. Direct care staff, [DOH 8/1/04], failed to receive certification in adult first aid within the first 30 days of employment. EMPLOYEE DID RECEIVE THE TRAINING BUT NOT WITHIN 30 DAYS OF EMPLOYMENT.

8817-G: Annual Training **Not Met**

Findings/Corrections

8817 G. 1. The Provider failed to ensure that each direct care worker, [DOH 1/16/96; 2/9/98; 6/18/98], participated in in-service training each year. THREE OF THREE EMPLOYEES WHOSE RECORDS WERE REVIEWED.

8817-H: Evaluation **Not Met**

Findings/Corrections

8817 H. The annual employee performance evaluation for [ALL EMPLOYEES] failed to include his/her interaction with residents, family, and other providers. PROVIDER NO LONGER USES AN EVALUATION FORM. INSTEAD THEY USE A MERIT INCREASE FORM AND BRIEFLY MAKE COMMENTS BUT NOT ALWAYS ADDRESSING THE WORKER INTERACTION WITH RESIDENTS, FAMILY AND OTHER PROVIDERS.

8821-B: Resident Association **Not Met**

Findings/Corrections

8821 B. The Provider failed to provide a formal process and structure by which residents, in representative groups and/or as a whole, were given the opportunity to advise the director regarding resident services and life at the facility. Residents' requests, concerns or suggestions presented through the resident association failed to be addressed by the director within a reasonable time frame, as necessitated by the concern, request or suggestion. THERE IS NO DOCUMENTATION OF FOLLOW-UP TO RESIDENTS REQUESTS, CONCERNS ETC.

Statement of Deficiencies

8827-A: Assessment, Service Coordination and Monitoring **Not Met**

Findings/Corrections

8827 A. 5. The resident's service plan failed to be revised and signed by the resident and the representative, when applicable, and the designated facility staff when a resident's condition or preferences changed. SEVEN SERVICE PLANS FAILED TO ALWAYS BE SIGNED BY THE RESIDENT OR THE PROVIDER STAFF.
8827 A. 6. The service plan failed to be monitored on an ongoing basis to determine its continued appropriateness and to identify when a resident's condition or preferences changed. There failed to be a documented review of the service plan at least every quarter. SERVICE PLANS ARE NOT ALWAYS MONITORED QUARTERLY AS EVIDENCED BY RECORDS REVIEWED. CHANGES ARE MADE TO THE ORIGINAL SERVICE PLAN BUT DATES ARE NOT RECORDED SO IT IS NOT CLEAR WHEN THE CHANGES OCCURRED.
8827 A. 7. Each service plan and review failed to be signed by the resident, facility staff, and the representative.

8827-C,D: Medications and Health Related Services **Not Met**

Findings/Corrections

8827 C. 2. The Provider failed to assist residents in the self-administration of prescription and non-prescription medication as agreed to in their contract or service plan and as allowed by state statute/regulations. MEDICATION ASSISTANCE WAS OBSERVED FOR SEVEN RESIDENTS. STAFF OPENED THE MEDI-PAC LID FOR FOUR OF THE SEVEN RESIDENTS. NONE OF THE FOUR WERE ABLE TO STATE WHAT THEY WERE TAKING AND WHY THEY WERE TAKING THE PILL. STAFF POURED THE MEDICATION INTO THE HAND OF ONE RESIDENT WHO WAS NOT ABLE TO STATE WHAT PILLS SHE WAS TAKING AND WHY SHE WAS TAKING THE PILLS.

8827 C. 3. (a.-e.) Assistance with self-administration of medications failed to be limited to the following:
a. The resident may be reminded to take his/her medications.
b. The medication regimen, as indicated on the container may be read to the resident.
c. The dosage may be checked according to the container label.
d. The staff may open the medicine container (i.e., bottle, mediset, blister pak, etc.), if the resident lacks the ability to open the container.
e. The resident may be physically assisted in pouring or otherwise taking medications, so long as the resident is cognitive of what the medication is, what is for and the need for the medication.
SEE DEFICIENCY 8827C2
8827 C. 7. An employee that provided assistance with the self-administration of medications to a resident failed to have documented training on the policies and procedures for medication assistance including the limitations of this assistance. Documentation failed to include the signature of the employee. Training on the policies and procedures for medication assistance including the limitations of assistance failed to be provided annually to employees providing assistance with the self administration of medications. ANNUAL TRAINING WAS NOT DOCUMENTED FOR DOH 6/18/98; 1/16/96.

8827-E: Transportation **Not Met**

Findings/Corrections

8827 E. 3. The Provider failed to document and ensure that drivers have a clean driving record.

8827-G: Menus **Not Met**

Findings/Corrections

8827 G. 2. The Provider failed to furnish medically prescribed diets to residents for which it contracted either in the contract or in the service plan. Menus for medically prescribed diets failed to be planned or approved by a registered licensed dietitian. *ONE RESIDENT IS ON A 1800 ADA DIET PER DOCTORS ORDERS. THERE ARE NO MEALS PLANNED BY THE DIETITIAN FOR THIS DIET.
** THERE IS A RESIDENT ON A RENAL TYPE DIET. DOCTORS ORDERS GIVE INSTRUCTIONS FOR LIMITING FOODS BUT SOME OF THE LIMITED FOODS IS LISTED ON THE MENU PREPARED BY THE DIETITIAN. IE POTATOES ARE NOT ALLOWED BUT THEY WERE LISTED IN SEVERAL MEALS DURING ONE WEEK.
8827 G. 3. Records of all menus as served failed to be kept on file for at least 30 days. DOCUMENTATION OF MEALS ACTUALLY SERVED TO RESIDENTS IS NOT KEPT. SUBSTITUTIONS ARE MADE TO THE ORGINAL MENU BUT THE SUBSTITUTED MENU IS NOT KEPT FOR THIRTY DAYS.